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SENATE BILL 2505
By Dixon

a*3,4,9,33,56,68,71

AN ACT to amend Tennessee Code Annotated, Title 3; Title 4; Title 9; Title 33; Title 56; Title 68 and Title 71, relative to providing affordable health insurance to businesses and individuals while controlling costs.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. This act may be known and cited as the "VolunteerCare Universal Health Care Coverage for Tennessee Act of 2004."

SECTION 2. Tennessee Code Annotated, Section 71-5-106, is amended by adding the following as a new subsection:

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(1) To the extent that a federal waiver or modification of an existing waiver has been obtained pursuant to Section 24 of this act the department shall provide for the delivery of federally approved medical assistance services to the following persons in addition to those persons otherwise eligible under this section:

(A) A qualified woman during her pregnancy and up to sixty (60) days following delivery when the woman's family income is equal to or below two hundred percent (200%) of the nonfarm income official poverty line;

(B) An infant under one (1) year of age when the infant's family income is equal to or below two hundred percent (200%) of the nonfarm income official poverty line;

(C) A qualified elderly person when the person's family income is equal to or below one hundred percent (100%) of the nonfarm income official poverty line and a qualified disabled person when that person's family income is equal to or below one hundred twenty-five percent (125%) of the nonfarm income official poverty line;

(D) A child one (1) year of age or older and under nineteen (19) years of age when the child's family income is equal to or below two hundred percent (200%) of the nonfarm income official poverty line;

(E) The parent or caretaker relative of a child described in subdivisions (B) and (C) when the child's family income is equal to or below two hundred percent (200%) of the nonfarm income official poverty line, subject to adjustment by the commissioner under this subsection. Medical assistance services provided under this subdivision must be provided within the limits of the program budget. Funds appropriated for services under this subdivision must include an annual inflationary adjustment equivalent to the rate of inflation in the medical assistance program. On a quarterly basis, the commissioner shall determine the fiscal status of program expenditures under this subdivision. If the commissioner determines that expenditures will exceed the funds available to provide medical assistance coverage pursuant to this paragraph, the commissioner must adjust the income eligibility limit for new applicants to the extent necessary to operate the program within the program budget. If, after an adjustment has occurred pursuant to this subdivision, expenditures fall below the program budget, the commissioner must raise the income eligibility limit to the extent necessary to provide services to as many eligible persons as possible within the fiscal constraints of the program budget, as long as the income limit does not exceed two hundred percent (200%) of the nonfarm income official poverty line; and

(F) A person twenty (20) to sixty-four (64) years of age who is not otherwise covered under subdivisions (A) to (E) when the person's family income is below or equal to one hundred twenty-five percent (125%) of the nonfarm income official poverty line, provided that the commissioner shall adjust the maximum eligibility level in accordance with the requirements of the subsection.

(2) If the commissioner reasonably anticipates the cost of the program to exceed the budget of the population described in this subsection, the commissioner shall lower the maximum eligibility level to the extent necessary to provide coverage to as many persons as possible within the program budget.

(3) The commissioner shall give at least thirty (30) days' notice of the proposed change in maximum eligibility level to the standing committees of the general assembly having jurisdiction over appropriations and financial affairs and the standing committees of the general assembly having jurisdiction over health and human services matters.

(4) For the purposes of this subsection, the "nonfarm income official poverty line" is that applicable to a family of the size involved, as defined by the federal department of health and human services and updated annually in the Federal Register under authority of 42 United States Code, Section 9902(2). For purposes of this subsection, "program budget" means the amounts available from both federal and state sources to provide federally approved medical assistance services.

(5) The provisions of this subsection shall take effect on the date that coverage is first provided to eligible employees and eligible individuals under VolunteerCare Health Insurance as established under Section 56-54-110.

SECTION 3. Tennessee Code Annotated, Title 71, Chapter 5, Part 1, is amended by adding the following as a new section:

71-5-199.

(a) The department may contract with one (1) or more health insurance carriers to purchase VolunteerCare Health Insurance for TennCare members who seek to enroll through their employers pursuant to Title 71, Chapter 5, Part 1. A TennCare member who enrolls in a VolunteerCare Health Insurance plan as a member of an employer group receives full TennCare benefits through VolunteerCare Health Insurance. The benefits are delivered through the employer-based health plan, subject to nominal cost sharing as permitted by 42 United States Code, Section 1396o(2003) and additional coverage provided under contract by the department.

(b) When a federally qualified health center otherwise meeting the requirements of subsection (a) contracts with a managed care plan or VolunteerCare Health Insurance for the provision of TennCare services, the department shall reimburse that center the difference between the payment received by the center from the managed care plan or VolunteerCare Health Insurance and one hundred percent (100%) of the reasonable cost, reduced by the total copayments for which members are responsible, incurred in providing services within the scope of service approved by the federal Health Resources and Services Administration or the commissioner. Any such managed care contract must provide payments for the services of a center that are not less than the level and amount of payment that the managed care plan or VolunteerCare Health Insurance would make for services provided by an entity not defined as a federally qualified health center.

SECTION 4. Tennessee Code Annotated, Title 56, is amended by adding the following as a new Chapter 54:

CHAPTER 54

VOLUNTEERCARE HEALTH

Part 1

56-54-101. This chapter may be known and cited as "the VolunteerCare Health Act."

56-54-102. VolunteerCare Health is established as an independent executive agency to arrange for the provision of comprehensive, affordable health care coverage to eligible small employers, including the self-employed, their employees and dependents, and individuals on a voluntary basis. VolunteerCare Health is also responsible for monitoring and improving the quality of health care in this state. The exercise by VolunteerCare Health of the powers conferred by this chapter must be deemed and held to be the performance of essential governmental functions.

56-54-103. As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

(1) "Board" means the board of directors of VolunteerCare Health, as established in section 56-54-104.

(2) "Child" means a natural child, stepchild, adopted child or child placed for adoption with a plan enrollee.

(3) "Dependent" means a spouse, an unmarried child under nineteen (19) years of age, a child who is a student under twenty-three (23) years of age and is financially dependent upon a plan enrollee or a person of any age who is the child of a plan enrollee and is disabled and dependent upon that plan enrollee.

(4) "Eligible business" means a business that employs at least two (2) but not more than fifty (50) eligible employees, the majority of whom are employed in the state, including a municipality that has fifty (50) or fewer employees. After one (1) year of operation of VolunteerCare Health, the board may, by rule, define "eligible business" to include larger public or private employers.

(5) "Eligible employee" means an employee of an eligible business who works at least twenty (20) hours per week for that eligible business. "Eligible employee" does not include an employee who works on a temporary or substitute basis or who does not work more than twenty-six (26) weeks annually.

(6) "Eligible individual" means:

(A) A self-employed individual who:

(i) Works and resides in the state; and

(ii) Is organized as a sole proprietorship or in any other legally recognized manner in which a self-employed individual may organize, a substantial part of whose income derives from a trade or business through which the individual has attempted to earn taxable income;

(B) An unemployed individual who resides in this state; or

(C) An individual employed in an eligible business that does not offer health insurance.

(7) "Employer" means the owner or responsible agent of a business authorized to sign contracts on behalf of the business.

(8) "Executive director" means the executive director of VolunteerCare Health.

(9) "Health insurance carrier" means:

(A) An insurance company licensed in accordance with Title 56 to provide health insurance;

(B) A health maintenance organization licensed pursuant to Title 56;

(C) A preferred provider arrangement administrator registered pursuant to Title 56;

(D) A nonprofit hospital or medical service organization or health plan licensed pursuant to Title 56; or

(E) An employee benefit excess insurance company licensed in accordance with Title 56 to provide property and casualty insurance that provides employee benefit excess insurance.

(10) "Health plan in Medicaid" means a health insurance carrier that meets the requirements of 42 Code of Federal Regulations, Part 438 (2002) and has a contract with the bureau of TennCare to provide TennCare-covered services to individuals enrolled in TennCare.

(11) "Participating employer" means an eligible business that contracts with VolunteerCare Health pursuant to section 56-54-110(d)(2), and that has employees enrolled in VolunteerCare Health Insurance.

(12) "Plan enrollee" means an eligible individual or eligible employee who enrolls in VolunteerCare Health Insurance through VolunteerCare Health. "Plan enrollee" includes an eligible employee who is eligible to enroll in TennCare.

(13) "Provider" means any person, organization, corporation or association that provides health care services and products and is authorized to provide those services and products under the laws of this state.

(14) "Reinsurance" and "reinsurer" have the same meanings as in section 56-6-802.

(15) "Resident" has the same meaning as in section 71-5-103.

(16) "Subsidy" means a subsidy as described in section 56-54-112.

(17) "Third-party administrator" means any person who, on behalf of any person who establishes a health insurance plan covering residents, receives or collects charges, contributions or premiums for or settles claims on residents in connection with any type of health benefit provided in or as an alternative to insurance.

(18) "Unemployed individual" means an individual who does not work more than twenty (20) hours a week for any single employer.

(19) "VolunteerCare Health Insurance" means the health insurance product established by VolunteerCare Health that is offered by a private health insurance carrier or carriers.

56-54-104.

(a) VolunteerCare Health which operates under the supervision of a board of directors is established in accordance with this section. The board consists of five (5) voting members and three (3) ex officio, nonvoting members as follows:

(1) The five (5) voting members of the board must be appointed by the governor, subject to review by the standing committees of the general assembly having jurisdiction over health insurance matters and confirmation by resolution or joint resolution of each house of the general assembly.

(2) The three (3) ex officio, nonvoting members of the board are:

(A) The commissioner of commerce and insurance or the commissioner's designee;

(B) A member of the staff of the office of the governor designated by the governor; and

(C) The commissioner of administrative and financial services or the commissioner's designee.

(b) Voting members of the board:

(1) Must have knowledge of and experience in one (1) or more of the following areas:

(A) Health care purchasing;

(B) Health insurance;

(C) TennCare;

(D) Health policy and law;

(E) State management and budget; or

(F) Health care financing; and

(2) Except as provided in this subsection, may not be:

(A) A representative or employee of an insurance carrier authorized to do business in this state;

(B) A representative or employee of a health care provider operating in this state; or

(C) Affiliated with a health or health-related organization regulated by state government.

A nonpracticing health care practitioner, retired or former health care administrator or retired or former employee of a health insurance carrier is not prohibited from being considered for board membership as long as that person is not currently affiliated with a health or health-related organization.

(c) Voting members serve three-year terms. Voting members may serve up to two (2) consecutive terms. Of the initial appointees, one (1) member serves an initial term of one (1) year, two (2) members serve initial terms of two (2) years and two (2) members serve initial terms of three (3) years. The governor shall fill any vacancy for an unexpired term in accordance with subsections (a) and (b). Members reaching the end of their terms may serve until replacements are named.

(d) The governor shall appoint one (1) of the voting members as the chair of the board.

(e) Three (3) voting members of the board constitute a quorum.

(f) An affirmative vote of three (3) members is required for any action taken by the board.

(g) A member of the board shall be compensated in the same manner as members of the general assembly pursuant to section 3-1-106; a member must receive compensation whenever that member fulfills any board duties in accordance with board bylaws.

(h) The board shall meet at least four (4) times a year at regular intervals and may also meet at other times at the call of the chair or the executive director. All meetings of the board are public proceedings within the meaning of Title 8, Chapter 44.

56-54-105.

A member of the board or an employee of VolunteerCare Health is not subject to any personal liability for having acted within the course and scope of membership or employment to carry out any power or duty under this chapter. VolunteerCare Health shall indemnify any member of the board and any employee of VolunteerCare Health against expenses actually and necessarily incurred by that member or employee in connection with the defense of any action or proceeding in which that member or employee is made a party by reason of past or present authority with VolunteerCare Health.

56-54-106.

Board members and employees of VolunteerCare Health and their spouses and dependent children may not receive any direct personal benefit from the activities of VolunteerCare Health in assisting any private entity, except that they may participate in VolunteerCare Health Insurance on the same terms as others may under this chapter. This section does not prohibit corporations or other entities with which board members are associated by reason of ownership or employment from participating in activities of VolunteerCare Health or receiving services offered by VolunteerCare Health as long as the ownership or employment is made known to the board and, if applicable, the board members abstain from voting on matters relating to that participation.

56-54-107.

(a) Except as otherwise provided in this section, information obtained by VolunteerCare Health under this chapter is a public record within the meaning of Title 10, Chapter 7, Part 5.

(b) Any personally identifiable financial information, supporting data or tax return of any person obtained by VolunteerCare Health under this chapter is confidential and not open to public inspection.

(c) Health information obtained by VolunteerCare Health under this chapter that is covered by the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, 110 Stat. 1936 or information otherwise covered as confidential by law is confidential and not open to public inspection.

56-54-108.

(a) Subject to any limitations contained in this chapter or in any other law, VolunteerCare Health may:

(1) Take any legal actions necessary or proper to recover or collect savings offset payments due VolunteerCare Health or that are necessary for the proper administration of VolunteerCare Health;

(2) Make and alter bylaws, not inconsistent with this chapter or with the laws of this state, for the administration and regulation of the activities of VolunteerCare Health;

(3) Have and exercise all powers necessary or convenient to effect the purposes for which VolunteerCare Health is organized or to further the activities in which VolunteerCare Health may lawfully be engaged, including the establishment of VolunteerCare Health Insurance;

(4) Engage in legislative liaison activities, including gathering information regarding legislation, analyzing the effect of legislation, communicating with Legislators and attending and giving testimony at legislative sessions, public hearings or committee hearings;

(5) Take any legal actions necessary to avoid the payment of improper claims against VolunteerCare Health or the coverage provided by or through

VolunteerCare Health, to recover any amounts erroneously or improperly paid by VolunteerCare Health, to recover any amounts paid by VolunteerCare Health as a result of mistake of fact or law and to recover other amounts due VolunteerCare Health;

(6) Enter into contracts with qualified third parties both private and public for any service necessary to carry out the purposes of this chapter;

(7) Conduct studies and analyses related to the provision of health care, health care costs and quality;

(8) Establish and administer a revolving loan fund to assist health care practitioners and health care providers in the purchase of hardware and software necessary to implement the requirements for electronic submission of claims. VolunteerCare Health may solicit matching contributions to the fund from each health insurance carrier licensed to do business in this state;

(9) Apply for and receive funds, grants or contracts from public and private sources;

(10) Provide staff support and other assistance to the Tennessee quality forum established in section 56-54-201, including assigning a director and other staff as needed to conduct the work of the Tennessee quality forum; and

(11) In accordance with the limitations and restrictions of this chapter, cause any of its powers or duties to be carried out by one (1) or more organizations organized, created or operated under the laws of this state.

(b) VolunteerCare Health shall:

(1) Establish administrative and accounting procedures as recommended by the state comptroller for the operation of VolunteerCare Health;

(2) Collect the savings offset payments provided in section 56-54-113;

(3) Determine the comprehensive services and benefits to be included in VolunteerCare Health Insurance and develop the specifications for VolunteerCare Health Insurance in accordance with the provisions in section 56-54-110. Within thirty (30) days of its determination of the benefit package to be

offered through VolunteerCare Health Insurance, the board shall report on the benefit package, including the estimated premium and applicable coinsurance, deductibles, copayments and out-of-pocket maximums, to the standing committees of the general assembly having jurisdiction over appropriations and financial affairs, the standing committees of the general assembly having jurisdiction over insurance and financial services matters and the standing committees of the general assembly having jurisdiction over health and human services matters;

(4) Develop and implement a program to publicize the existence of VolunteerCare Health and VolunteerCare Health Insurance and the eligibility requirements and the enrollment procedures for VolunteerCare Health Insurance and to maintain public awareness of VolunteerCare Health and VolunteerCare Health Insurance;

(5) Arrange the provision of VolunteerCare Health Insurance benefit coverage to eligible individuals and eligible employees through contracts with one (1) or more qualified bidders;

(6) Develop a high-risk pool for plan enrollees in VolunteerCare Health Insurance in accordance with the provisions of section 56-54-301; and

(7) Establish and operate the Tennessee quality forum in accordance with the provisions of section 56-54-201.

(c) The revenues and expenditures of VolunteerCare Health are subject to legislative approval in the budget process. At the direction of the board, the executive director shall prepare the budget for the administration and operation of VolunteerCare Health in accordance with the provisions of law that apply to departments of state government.

(d) VolunteerCare Health must be audited annually by the state comptroller. The board may, in its discretion, arrange for an independent audit to be conducted. A copy of the audit must be provided to the state treasurer, to the commissioner, to the standing committees of the general assembly having jurisdiction over appropriations and financial affairs, to the standing committees of the general assembly having jurisdiction over insurance and financial services matters and to the standing committees of the general assembly having jurisdiction over health and human services matters.

(e) VolunteerCare Health may adopt rules as necessary for the proper administration and enforcement of this chapter, pursuant to Title 4, Chapter 5.

(f) Beginning September 1, 2005, and annually thereafter, the board shall report on the impact of VolunteerCare Health on the small group and individual health insurance markets in this state and any reduction in the number of uninsured individuals in the state. The board shall also report on membership in VolunteerCare Health, the administrative expenses of VolunteerCare Health, the extent of coverage, the effect on premiums, the number of covered lives, the number of VolunteerCare Health Insurance policies issued or renewed and VolunteerCare Health Insurance premiums earned and claims incurred by health insurance carriers offering VolunteerCare Health Insurance. The board shall submit the report to the governor, the standing committees of the general assembly having jurisdiction over appropriations and financial affairs, the standing committees of the general assembly having jurisdiction over health insurance and financial services matters and the standing committees of the general assembly having jurisdiction over health and human services matters.

(g) Other state agencies, including, but not limited to, the bureau of TennCare, the department of human services and the department of revenue, shall provide technical assistance and expertise to VolunteerCare Health upon request.

(h) The attorney general and reporter, when requested, shall furnish any legal assistance, counsel or advice VolunteerCare Health requires in the discharge of its duties.

(i) VolunteerCare Health shall institute a system to coordinate the activities of VolunteerCare Health with the health care programs of the federal government and state and municipal governments.

(j) Upon request from the board, the governor shall provide staffing assistance to VolunteerCare Health in the initial phases of its operation.

(k) VolunteerCare Health may appoint advisory committees to advise and assist VolunteerCare Health. Members of an advisory committee serve without compensation but may be reimbursed by VolunteerCare Health for necessary expenses while on official business of the advisory committee.

56-54-109.

(a) The executive director is appointed by the board and serves at the pleasure of the board.

(b) The executive director shall:

(1) Serve as the liaison between the board of directors and VolunteerCare Health and serve as secretary and treasurer to the board;

(2) Manage VolunteerCare Health's programs and services, including the Tennessee quality forum established under section 56-54-201;

(3) Employ or contract on behalf of VolunteerCare Health for professional and nonprofessional personnel or service. Employees of VolunteerCare Health are subject to the provisions of Title 8, Chapter 30, except that the position of director of the Tennessee quality forum is not subject to the provisions of Title 8, Chapter 30;

(4) Approve all accounts for salaries, per diems, allowable expenses of VolunteerCare Health or of any employee or consultant and expenses incidental to the operation of VolunteerCare Health; and

(5) Perform other duties prescribed by the board to carry out the functions of this chapter.

56-54-110.

(a) VolunteerCare Health shall arrange for the provision of health benefits coverage through VolunteerCare Health Insurance not later than October 1, 2005. VolunteerCare Health Insurance must comply with all relevant requirements of this Title. VolunteerCare Health Insurance may be offered by health insurance carriers that apply to the board and meet qualifications described in this section and any additional qualifications set by the board.

(b) If health insurance carriers do not apply to offer and deliver VolunteerCare Health Insurance, the board may have VolunteerCare Health provide access to health insurance by proposing the establishment of a nonprofit health care plan or by proposing the expansion of an existing public plan. If the board proposes the establishment of a nonprofit health care plan or the expansion of an existing public plan, the board shall submit its proposal, including, but not limited to, a funding mechanism to capitalize a nonprofit health care plan and any recommended legislation to the standing committees of the general assembly having jurisdiction over health insurance matters. VolunteerCare Health may not provide access to health insurance by establishing a nonprofit health care plan or through an existing public plan without specific legislative approval.

(c) To qualify as a carrier of VolunteerCare Health Insurance, a health insurance carrier must:

(1) Provide comprehensive health services and benefits as determined by the board, including a standard benefit package that meets the requirements for mandated coverage for specific health services, specific diseases and for certain providers of health services under this title and any supplemental benefits the board wishes to make available; and

(2) Ensure that:

(A) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not charge plan enrollees or third parties for covered health care services in excess of the amount allowed by the carrier the provider has contracted with, except for applicable copayments, deductibles or coinsurance;

(B) Providers contracting with a carrier contracted to provide coverage to plan enrollees do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, citizenship status, gender, disability or marital status. This subitem may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

(C) Providers contracting with a carrier contracted to provide coverage to plan enrollees are reimbursed at the negotiated reimbursement rates between the carrier and its provider network.

(d) VolunteerCare Health has contracting authority and powers to administer VolunteerCare Health Insurance as set out in this subsection.

(1) VolunteerCare Health may contract with health insurance carriers licensed to sell health insurance in this state or other private or public third-party administrators to provide VolunteerCare Health Insurance. In addition:

(A) VolunteerCare Health shall issue requests for proposals from health insurance carriers;

(B) VolunteerCare Health may include quality improvement, disease prevention, disease management and cost-containment provisions in the contracts with participating health insurance carriers or may arrange for the provision of such services through contracts with other entities;

(C) VolunteerCare Health shall require participating health insurance carriers to offer a benefit plan identical to VolunteerCare Health Insurance, for which no VolunteerCare Health subsidies are available, in the general small group market;

(D) VolunteerCare Health shall make payments to participating health insurance carriers under a VolunteerCare Health Insurance contract to provide VolunteerCare Health Insurance benefits to plan enrollees not enrolled in TennCare;

(E) VolunteerCare Health may set allowable rates for administration and underwriting gains for VolunteerCare Health Insurance;

(F) VolunteerCare Health may administer continuation benefits for eligible individuals from employers with twenty (20) or more employees who have purchased health insurance coverage through VolunteerCare Health for the duration of their eligibility periods for continuation benefits pursuant to the federal Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, Title X, Private Health Insurance Coverage, Sections 10001 to 10003; and

(G) VolunteerCare Health may administer or contract to administer the United States Internal Revenue Code of 1986, Section 125 plans for employers and employees participating in VolunteerCare Health, including medical expense reimbursement accounts and dependent care reimbursement accounts.

(2) VolunteerCare Health shall contract with eligible businesses seeking assistance from VolunteerCare Health in arranging for health benefits coverage by VolunteerCare Health Insurance for their employees and dependents as set out in this subdivision.

(A) VolunteerCare Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(B) VolunteerCare Health shall collect payments from participating employers and plan enrollees to cover the cost of:

(i) VolunteerCare Health Insurance for enrolled employees and dependents in contribution amounts determined by the board;

(ii) VolunteerCare Health's quality assurance, disease prevention, disease management and cost-containment programs;

(iii) VolunteerCare Health's administrative services; and

(iv) Other health promotion costs.

(C) VolunteerCare Health shall establish the minimum required contribution levels, not to exceed sixty percent (60%), to be paid by employers toward the aggregate payment in subitem (2) of this subdivision and establish an equivalent minimum amount to be paid by employers or plan enrollees and their dependents who are enrolled in TennCare. The minimum required contribution level to be paid by employers must be prorated for employees that work less than the number of hours of a full-time equivalent employee as determined by the employer. VolunteerCare Health may establish a separate minimum contribution level to be paid by employers toward coverage for dependents of the employers' enrolled employees.

(D) VolunteerCare Health shall require participating employers to certify that at least seventy-five percent (75%) of their employees that work thirty (30) hours or more per week and who do not have other creditable coverage are enrolled in VolunteerCare Health Insurance and that the employer group otherwise meets the minimum participation requirements specified by law.

(E) VolunteerCare Health shall reduce the payment amounts for plan enrollees eligible for a subsidy under section 56-54-112 accordingly. VolunteerCare Health shall return any payments made by plan enrollees also enrolled in TennCare to those enrollees.

(F) VolunteerCare Health shall require participating employers to pass on any subsidy in section 56-54-112 to the plan enrollee qualifying for the subsidy, up to the amount of payments made by the plan enrollee.

(G) VolunteerCare Health may establish other criteria for participation.

(H) VolunteerCare Health may limit the number of participating employers.

(3) VolunteerCare Health may permit eligible individuals to purchase VolunteerCare Health Insurance for themselves and their dependents as set out in this subdivision.

(A) VolunteerCare Health may establish contract and other reporting forms and procedures necessary for the efficient administration of contracts.

(B) VolunteerCare Health may collect payments from eligible individuals participating in VolunteerCare Health Insurance to cover the cost of:

(i) Enrollment in VolunteerCare Health Insurance for eligible individuals and dependents;

(ii) VolunteerCare Health's quality assurance, disease prevention, disease management and cost-containment programs;

(iii) VolunteerCare Health's administrative services; and

(iv) Other health promotion costs.

(C) VolunteerCare Health shall reduce the payment amounts for individuals eligible for a subsidy under section 56-54-112 accordingly.

(D) VolunteerCare Health may require that eligible individuals certify that all their dependents are enrolled in VolunteerCare Health Insurance or are covered by another creditable plan.

(E) VolunteerCare Health may require an eligible individual who is currently employed by an eligible employer that does not offer health insurance to certify that the current employer did not provide access to an employer-sponsored benefits plan in the twelve-month period immediately preceding the eligible individual's application.

(F) VolunteerCare Health may limit the number of plan enrollees.

(G) VolunteerCare Health may establish other criteria for participation.

(e) VolunteerCare Health shall perform, at a minimum, the following functions to facilitate enrollment in VolunteerCare Health Insurance.

(1) VolunteerCare Health shall publicize the availability of VolunteerCare Health Insurance to businesses, self-employed individuals and others eligible to enroll in VolunteerCare Health Insurance.

(2) VolunteerCare Health shall screen all eligible individuals and employees for eligibility for subsidies under section 56-54-112 and eligibility for TennCare. To facilitate the screening and referral process, VolunteerCare Health shall provide a single application form for VolunteerCare Health and TennCare. The application materials must inform applicants of subsidies available through VolunteerCare Health and of the additional coverage available through TennCare. It must allow an applicant to choose on the application form to apply or not to apply for TennCare or for a subsidy. It must allow an applicant to provide household financial information necessary to determine eligibility for TennCare or a subsidy. Except when the applicant has declined to apply for TennCare or a subsidy, an application must be treated as an application for VolunteerCare Health, for a subsidy and for TennCare. The bureau of TennCare or its designee must make the final determination of eligibility for TennCare.

(3) Except as provided in this subdivision, the effective date of coverage for a new enrollee in VolunteerCare Health Insurance is the first day of the month following receipt of the fully completed application for that enrollee by the carrier contracting with VolunteerCare Health or the first day of the next month if the fully completed application is received by the carrier within ten (10) calendar days of the end of the month. If a new enrollee in VolunteerCare Health Insurance had prior coverage through an individual or small group policy, coverage under VolunteerCare Health Insurance must take effect the day following termination of that enrollee's prior coverage.

(f) VolunteerCare Health shall promote quality improvement, disease prevention, disease management and cost-containment programs as part of its administration of VolunteerCare Health Insurance.

56-54-111.

The department of finance and administration is the state agency responsible for the financing and administration of TennCare. It shall pay for TennCare benefits for TennCare-eligible individuals, including those enrolled in health plans in TennCare that are providing coverage under VolunteerCare Health Insurance.

56-54-112.

VolunteerCare Health may establish sliding-scale subsidies for the purchase of VolunteerCare Health Insurance paid by individuals or employees whose income is under three hundred percent (300%) of the federal poverty level and who are not eligible for TennCare. VolunteerCare Health may also establish sliding-scale subsidies for the purchase of employer-sponsored health coverage paid by employees of businesses with more than fifty (50) employees, whose income is under three hundred percent (300%) of the federal poverty level and who are not eligible for TennCare.

(a) VolunteerCare Health shall, by rule, establish procedures to administer this section.

(b) Individuals eligible for a subsidy must:

(1) Have an income under three hundred percent (300%) of the federal poverty level, be a resident of the state, be ineligible for TennCare coverage and be enrolled in VolunteerCare Health Insurance; or

(2) Be enrolled in a health plan of an employer with more than fifty (50) employees. The health plan must meet any criteria established by VolunteerCare Health. The individual must meet other eligibility criteria established by VolunteerCare Health.

(c) VolunteerCare Health shall limit the availability of subsidies to reflect limitations of available funds.

(d) VolunteerCare Health may limit the amount subsidized of the payment made by individual plan enrollees under section 56-54-110(d)(3) to forty percent (40%) of the payment to more closely parallel the subsidy received by employees. In no case may the subsidy granted to eligible individuals in accordance with subdivision (b)(1), exceed the maximum subsidy level available to other eligible individuals.

(e) VolunteerCare Health shall notify applicants and their employers in writing of their eligibility and approved level of subsidy.

(f) Within thirty (30) days after any subsidies are established pursuant to this section, the board shall report on the amount of the subsidies, the funding required for the subsidies and the estimated number of VolunteerCare Health enrollees eligible for the subsidies and submit the report to the standing committees of the general assembly having jurisdiction over appropriations and financial affairs, the standing committees of the general assembly having jurisdiction over insurance and financial services matters and the standing committees of the general assembly having jurisdiction over health and human services matters.

56-54-113.

(a) After an opportunity for a hearing, the board shall determine annually not later than April the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this state as a result of the operation of VolunteerCare Health and any increased enrollment due to an expansion in TennCare eligibility occurring after June 30, 2005.

(b) For the purpose of providing the funds necessary to provide subsidies pursuant to section 56-54-112 and support the Tennessee quality forum established pursuant to Part 2 of this chapter, the board shall establish a savings offset amount to be paid by health insurance carriers, employee benefit excess insurance carriers and third-party administrators, not including carriers and third-party administrators with respect to accidental injury, specified disease, hospital indemnity, dental, vision, disability, income, long-term care, Medicare supplement or other limited benefit health insurance, annually at a rate that may not exceed savings resulting from decreasing rates of growth in the state's health care spending and in bad debt and charity care costs. Payment of the savings offset amount must begin twelve (12) months after VolunteerCare Health begins providing health insurance coverage. The savings offset payment amount, as determined by the board, is the determining factor for inclusion of savings offset payments in premiums through rate setting review by the bureau. Savings offset payments must be made quarterly and are due not less than thirty (30) days after written notice to the health insurance carriers, employee benefit excess insurance carriers and third-party administrators and must accrue interest at twelve percent (12%) per annum on or after the due date.

(c) Each health insurance carrier and employee benefit excess insurance carrier must pay a savings offset in an amount not to exceed four percent (4%) of annual health insurance premiums and employee benefit excess insurance premiums on policies issued pursuant to the laws of this state that insure residents of this state. The savings offset payment may not exceed savings resulting from decreasing rates of growth in the state's health care spending and bad debt and charity care costs. The savings offset payment applies to premiums paid on or after July 1, 2006. Savings offset payments must reflect aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this state, as a result of the operation of VolunteerCare Health and any increased enrollment due to an expansion in TennCare eligibility occurring after June 30, 2005, as determined by the board consistent with subsection (a). A health insurance carrier and employee benefit excess insurance carrier may not be required to pay a savings offset payment on policies or contracts insuring federal employees.

(d) The board shall make reasonable efforts to ensure that premium revenue, or claims plus any administrative expenses and fees with respect to third-party administrators, is counted only once with respect to any savings offset payment. For that purpose, the board shall require each health insurance carrier to include in its premium revenue gross of reinsurance ceded. The board shall allow a health insurance carrier to exclude from its gross premium revenue reinsurance premiums that have been counted by the primary insurer for the purpose of determining its savings offset payment under this subsection. The board shall allow each employee benefit excess insurance carrier to exclude from its gross premium revenue the amount of claims that have been counted by a third-party administrator for the purpose of determining its savings offset payment under this subsection. The board may verify each health insurance carrier, employee benefit excess insurance carrier and third-party administrator's savings offset payment based on annual statements and other reports determined to be necessary by the board.

(e) The commissioner of commerce and insurance may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any health insurance carrier or employee benefit excess insurance carrier or the license of any third-party administrator to operate in this state that fails to pay a savings offset payment. In addition, the commissioner may assess civil penalties against any health insurance carrier, employee benefit excess insurance carrier or third-party administrator that fails to pay a savings offset payment or may take any other enforcement action authorized under Title 56 to collect any unpaid savings offset payments.

(f) On an annual basis no later than April of each year, the board shall prospectively determine the savings offset to be applied during each twelve (12)-month period. To make its determination, the board shall use the criteria and reports described in subsections (g) and (h). Annual offset payments must be reconciled to determine whether unused payments may be returned to health insurance carriers, employee benefit excess insurance carriers and third-party administrators according to a formula developed by the board. Savings offset payments must be used solely to fund the subsidies authorized by section 56-54-112 and to support the Tennessee quality forum established in Part 2 of this chapter and may not exceed savings from reductions in growth of the state's health care spending and bad debt and charity care.

(g) In accordance with the requirements of this subsection, every health insurance carrier and health care provider shall demonstrate that best efforts have been made to ensure that a carrier has recovered savings offset payments made pursuant to this section through negotiated reimbursement rates that reflect health care providers' reductions or stabilization in the cost of bad debt and charity care as a result of the operation of VolunteerCare Health and any increased enrollment due to an expansion in TennCare eligibility occurring after June 30, 2005.

(1) A health insurance carrier shall use best efforts to ensure health insurance premiums reflect any such recovery of savings offset payments as

those savings offset payments are reflected through incurred claims experience in accordance with subsection (i).

(2) During any negotiation with a health insurance carrier relating to a health care provider's reimbursement agreement with that carrier, a health care provider shall provide data relating to any reduction or avoidance of bad debt and charity care costs to health care providers in this state, as a result of the operation of VolunteerCare Health and as a result of any increased enrollment due to an expansion in TennCare eligibility occurring after June 30, 2005.

(h) The following reports are required in accordance with this subsection.

(1) On a quarterly basis beginning with the first quarter after VolunteerCare Health Insurance begins offering coverage, the board shall collect and report on the following:

(A) The total enrollment in VolunteerCare Health Insurance, including the number of enrollees previously underinsured or uninsured, the number of enrollees previously insured, the number of individual enrollees and the number of enrollees enrolled through small employers;

(B) The total number of enrollees covered in health plans through large employers and self-insured employers;

(C) The number of employers, both small employers and large employers, who have ceased offering health insurance or contributing to the cost of health insurance for employees or who have begun offering coverage on a self-insured basis;

(D) The number of employers, both small employers and large employers, who have begun to offer health insurance or contribute to the cost of health insurance premiums for their employees;

(E) The number of new participating employers in VolunteerCare Health Insurance;

(F) The number of employers ceasing to offer coverage through VolunteerCare Health Insurance;

(G) The duration of employers participating in VolunteerCare Health Insurance; and

(H) A comparison of actual enrollees in VolunteerCare Health Insurance to the projected enrollees.

(2) The board shall establish the total health care spending in the state for the base year of 2003 and shall annually determine, in collaboration with the commissioner of commerce and insurance, appropriate actuarially supported trend factors that reflect savings consistent with subsection (a) and compare rates of spending growth to the base year of 2003. The board shall collect on an annual basis, in consultation with the commissioner, the total cost to the state's health care providers of bad debt and charity care beginning with the base year of 2003. This information may be compiled through mechanisms, including, but not limited to, standard reporting or statistically accurate surveys of providers and practitioners. The board shall utilize existing data on file with state agencies or other organizations to minimize duplication. The comparisons to the base year must be reported beginning March 1, 2005 and annually thereafter.

(3) Health insurance carriers and health care providers shall report annually, beginning March 1, 2006 and thereafter, information regarding the experience of a prior twelve (12)-month period on the efforts undertaken by the carrier and provider to recover savings offset payments, as reflected in reimbursement rates, through a reduction or stabilization in bad debt and charity care costs as a result of the operation of VolunteerCare Health and any increased enrollment due to an expansion in TennCare eligibility occurring after June 30, 2005. The board shall determine the appropriate format for the report and utilize existing data on file with state agencies or other organizations to minimize duplication. The report must be submitted to the board. Using the information submitted by carriers and providers, the board shall submit a summary of that information by October 1, 2006 and annually thereafter.

(4) The quarterly reports required to be submitted by the board pursuant to subdivision (1) and the annual reports required to be submitted by the board pursuant to subdivisions (2) and (3) must be submitted to the commissioner, to the standing committees of the general assembly having jurisdiction over appropriations and financial affairs, to the standing committees of the general assembly having jurisdiction over insurance and financial services matters, and to the standing committees of the general assembly having jurisdiction over health and human services matters.

(i) The claims experience used to determine any filed premiums or rating formula must reasonably reflect, in accordance with accepted actuarial standards, known changes and offsets in payments by the carrier to health care providers in this state, including any reduction or avoidance of bad debt and charity care costs to health care providers in this state as a result of the operation of VolunteerCare Health and any increased enrollment due to an expansion in TennCare eligibility occurring after June 30, 2005 as determined by the board consistent with subsection (a).

56-54-114.

Starting July 1, 2005, VolunteerCare Health shall transfer funds, as necessary, to a special dedicated, nonlapsing revenue account administered by the agency of state government that administers TennCare for the purpose of providing a state match for federal Medicaid dollars. VolunteerCare Health shall annually set the amount of contribution. The transfer may not include money collected as a savings payment offset pursuant to section 56-54-113.

56-54-115.

The VolunteerCare Health Fund is created as a general fund reserve, to be allocated by the general appropriations act, for the deposit of any funds advanced for initial operating expenses, payments made by employers and individuals, any savings offset payments made pursuant to section 56-54-113 and any funds received from any public or private source. Monies from the fund shall be expended to carry out the purposes of this chapter. Any revenues deposited in this reserve shall remain in the reserve until expended for purposes consistent with this chapter and shall not revert to the general fund on any June 30. Any excess revenues on interest earned by such revenues shall not revert on any June 30, but shall remain available for appropriation in subsequent fiscal years.

PART 2

HEALTH CARE QUALITY

56-54-201.

The Tennessee quality forum, referred to in this part as "the forum," is established within VolunteerCare Health. The forum is governed by the board with advice from the Tennessee quality forum advisory council pursuant to section 56-54-202. The forum must be funded, at least in part, through the savings offset payments made pursuant to section 56-54-113. Except as provided in section 56-54-107(c), information obtained by the forum is a public record as provided by Title 10, Chapter 7, Part 5. The forum shall perform the following duties:

(1) The forum shall collect and disseminate research regarding health care quality, evidence-based medicine and patient safety to promote best practices.

(2) The forum shall adopt a set of measures to evaluate and compare health care quality and provider performance. The measures must be adopted with guidance from the advisory council pursuant to section 56-54-202. The quality measures adopted by the forum must be the basis for the rules for the collection of quality data adopted by the Tennessee health data organization pursuant to Section 68-1-2201.

(3) The forum shall coordinate the collection of health care quality data in the state. The forum shall work with the Tennessee health data organization and other entities that collect health care data to minimize duplication and to minimize the burden on providers of data.

(4) The forum shall work collaboratively with the Tennessee health data organization, health care providers, health insurance carriers and others to report in useable formats comparative health care quality information to consumers, purchasers, providers, insurers and policy makers. The forum shall produce annual quality reports in conjunction with the Tennessee health data organization pursuant to Section 68-1-2203.

(5) The forum shall conduct education campaigns to help health care consumers make informed decisions and engage in healthy lifestyles.

(6) The forum shall conduct technology assessment reviews to guide the use and distribution of new technologies in this state. The forum shall make recommendations to the certificate of need program under Title 68, Chapter 11, Part 16.

(7) The forum shall encourage the adoption of electronic technology and assist health care practitioners to implement electronic systems for medical records and submission of claims. The assistance may include, but is not limited to, practitioner education, identification or establishment of low-interest financing options for hardware and software and system implementation support.

(8) The forum shall make recommendations for inclusion in the State Health Plan described under Title 2, Chapter 5, including recommendations based on the technology assessment reviews under item (6).

(9) The forum shall make an annual report to the public. The forum shall provide the report to the standing committees of the general assembly having jurisdiction over appropriations and financial affairs, health and human services matters and insurance and financial services matters.

56-54-202.

(a) The Tennessee quality forum advisory council, hereinafter referred to in this section as "the advisory council," is established. The advisory council shall consist of seventeen (17) members. The purpose of the council is to advise the forum. Except as provided in section 56-54-107(c), information obtained by the advisory council is a public record as provided by Title 10, Chapter 7, Part 5.

(b) The governor shall appoint the following members to the council:

(1) Seven (7) members representing providers, including three (3) physicians, one (1) registered nurse, one (1) representative of hospitals, one (1) mental health provider and one (1) health care practitioner who is not a physician. The three (3) physician members must represent medical physicians, osteopathic physicians, primary care physicians and specialist physicians;

(2) Four (4) members representing consumers, including one (1) employee who receives health care through a commercially insured product, one (1) representative of organized labor, one (1) representative of a consumer health advocacy group and one (1) representative of the uninsured or TennCare recipients;

(3) Four (4) members representing employers, including one (1) member of the state employee insurance committee, one (1) representative of a private employer with more than one thousand (1,000) full-time equivalent employees, one (1) representative of a private employer with fifty (50) to one thousand (1,000) full-time employees and one (1) representative of a private employer with fewer than fifty (50) employees;

(4) One (1) representative of a private health plan; and

(5) One (1) representative of the TennCare program.

Prior to making appointments to the advisory council, the governor shall seek nominations from the public and from a statewide medical association, a statewide osteopathic association, a statewide hospital association, a statewide nurses association, a statewide health purchasing collaborative, a statewide health management coalition, organized labor, a statewide organization representing consumers advocating for affordable health care, a statewide association representing consumers of mental health services, a national association of retired persons, a statewide citizen action organization, a statewide organization advocating equal justice, a statewide organization representing local chambers of commerce, a statewide organization representing businesses for social responsibility, a statewide small business alliance, a national federation of independent businesses, a statewide association of health plans and other entities as appropriate.

(c) Members of the advisory council serve five-year terms except for initial appointments. Initial appointments must include five (5) members appointed to three-year terms, six (6) members appointed to four-year terms and six (6) members appointed to five-year terms. A member may not serve more than two (2) consecutive terms.

(d) Members of the advisory council are eligible for compensation according to reimbursement for expenses in accordance with the provisions of the comprehensive travel regulations promulgated by the commissioner of finance and administration.

(e) A quorum is a majority of the members of the advisory council.

(f) The advisory council shall annually choose one (1) of its members to serve as chair for a one-year term. The advisory council may select other officers and designate their duties.

(g) The advisory council shall meet at least four (4) times a year at regular intervals and may meet at other times at the call of the chair or the executive director of VolunteerCare Health. Meetings of the council are public proceedings as provided by Title 8, Chapter 44.

(h) The advisory council shall:

(1) Convene a group of health care providers to provide input and advice to the council. The council shall invite members broadly representing health care practitioners, health care providers, federally qualified health centers and pharmacists. Members serve as volunteers and without compensation or reimbursement for expenses;

(2) Provide expertise in health care quality to assist the board;

(3) Advise and support the forum by:

(A) Establishing and monitoring, with VolunteerCare Health, an annual work plan for the forum;

(B) Providing guidance in the adoption of quality and performance measures;

(C) Serving as a liaison between the provider group established in subdivision (h)(1) and the forum;

(D) Conducting public hearings and meetings; and

(E) Reviewing consumer education materials developed by the forum;

(4) Make recommendations regarding quality assurance and quality improvement priorities for inclusion in the state health plan described in Title 4, Chapter 52; and

(5) Serve as a liaison between the forum and other organizations working in the field of health care quality.

PART 3

VOLUNTEERCARE HEALTH HIGH-RISK POOL

56-54-301.

(a) VolunteerCare Health shall establish the VolunteerCare Health High-risk Pool, referred to in this section as "the high-risk pool" for plan enrollees in accordance with this section.

(b) A plan enrollee must be included in the high-risk pool if:

(1) The total cost of health care services for the enrollee exceeds one hundred thousand dollars ($100,000) in any twelve (12)-month period; or

(2) The enrollee has been diagnosed with one (1) or more of the following conditions: acquired immune deficiency syndrome (HIV/AIDS), angina pectoris, cirrhosis of the liver, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington's chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, myasthenia gravis, myotonia, heart disease requiring open-heart surgery, Parkinson's disease, polycystic kidney disease, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease.

(c) VolunteerCare Health shall develop appropriate disease management protocols, develop procedures for implementing those protocols and determine the manner in which disease management must be provided to plan enrollees in the high-risk pool. VolunteerCare Health may include disease management in its contract with participating carriers for VolunteerCare Health Insurance pursuant to section 56-54-110, contract separately with another entity for disease management services or provide disease management services directly through VolunteerCare Health.

(d) VolunteerCare Health shall submit a report, no later than January 1, 2007, outlining the disease management protocols, procedures and delivery mechanisms used to provide services to plan enrollees. The report must also include the number of plan enrollees in the high-risk pool, the types of diagnoses managed within the high-risk pool, the claims experience within the high-risk pool and the number and type of claims exceeding one hundred thousand dollars ($100,000) for enrollees in the high-risk pool and for all enrollees in VolunteerCare Health Insurance. The report must be submitted to the standing committees of the general assembly having jurisdiction over health insurance matters.

(e) After three (3) years of operation, but no later than October 1, 2008, VolunteerCare Health shall evaluate the impact of VolunteerCare Health on average premium rates in this state and on the rate of uninsured individuals in this state and compare the trends in those rates to the trends in the average premium rates and average rates of uninsured individuals for the states that have established a statewide high-risk pool as of July 1, 2004. The board shall submit the evaluation of the impact of VolunteerCare Health in this state in comparison to states with high-risk pools to the standing committees of the general assembly having jurisdiction over health insurance matters by January 1, 2008. If the trend in average premium rates in this state and rate of uninsured individuals exceed the trend for the average among the states with high-risk pools, the board shall submit legislation by January 15, 2009 to the general assembly that proposes to establish a statewide high-risk pool in this state consistent with the characteristics of high-risk pools operating in other states.

SECTION 5. Tennessee Code Annotated, Title 71, Chapter 5, is amended by adding the following as a new part:

75-5-2501.

The department of finance and administration shall provide a monthly report of enrollment and expenditures for the noncategorical adults enrolled in the TennCare program.

The report must include the number of members, expenses and projections for expenses in the state fiscal year for members enrolled under the waiver expansion of eligibility.

71-5-2502.

The governor's office and the board of directors of VolunteerCare Health, established pursuant to Title 56, Chapter 54, shall develop a methodology to determine an appropriate savings offset payment to be paid by third-party administrators as required by section 56-54-113. In developing the methodology, the governor's office and the board shall consult with and reach consensus among self-insured employers, multiple-employer welfare arrangements and third-party administrators. The methodology must take into account both the similarities and the differences that exist between self-insured plans, multiple-employer welfare arrangements and health insurance. No later than February 1, 2005, the board shall report on the methodology, including recommended legislation to implement the savings offset payments, to the general assembly.

SECTION 6. Tennessee Code Annotated, Title 4, is amended by adding the following as a new Chapter 52:

4-52-101.

(a) The governor or the governor's designee shall:

(1) Develop and issue the biennial State Health Plan, referred to in this chapter as "the plan," pursuant to section 4-52-103. The first plan must be issued by May 2005;

(2) Make an annual report to the public assessing the progress toward meeting goals of the plan and provide any needed updates to the plan;

(3) Issue an annual statewide health expenditure budget report that must serve as the basis for establishing priorities within the plan; and

(4) Establish a limit, called the capital investment fund, for each year of the plan pursuant to section 4-52-102.

(b) The governor shall provide the reports specified in subdivisions (a)(2) and (3) to the standing committees of the general assembly having jurisdiction over appropriations and financial affairs, the standing committees of the general assembly having jurisdiction over health and human services matters and the standing committees of the general assembly having jurisdiction over insurance and financial services matters.

4-52-102.

(a) The capital investment fund is a limit for resources allocated annually under the certificate of need program described in Title 68, Chapter 11, Part 16.

(b) The process for determining the capital investment fund amount must be set forth in rules and may include the formation of an ad hoc expert panel to advise the governor. The process must include the division of the total capital investment fund amount into nonhospital and hospital components, must establish large and small capital investment fund amounts within each component and must be based on capital and operating expenses of projects under the certificate of need program. The process must take into account the following:

(1) The plan;

(2) The opportunity for improved operational efficiencies in the state's health care system;

(3) The average age of the infrastructure of the state's health care system; and

(4) Technological developments and the dissemination of technology in health care.

(c) For the first three (3) years of the plan, the nonhospital component of the capital investment fund must be at least twelve and one-half percent (12.5%) of the total. This subsection is repealed July 1, 2008.

4-52-103.

(a) The plan issued pursuant to section 4-52-101(a)(1) must set forth a comprehensive, coordinated approach to the development of health care facilities and resources in the state based on statewide cost, quality and access goals and strategies to ensure access to affordable health care, maintain a rational system of health care and promote the development of the health care workforce.

(b) In developing the plan, the governor shall, at a minimum, seek input from the advisory council on health systems development, pursuant to section 4-52-104; the Tennessee quality forum and the Tennessee quality forum advisory council, pursuant to Title 56, Chapter 54, Part 2; and other agencies and organizations.

(c) The plan must:

(1) Assess health care cost, quality and access in the state;

(2) Develop benchmarks to measure cost, quality and access goals and report on progress toward meeting those goals;

(3) Establish and set annual priorities among health care cost, quality and access goals;

(4) Prioritize the capital investment needs of the health care system in the state within the capital investment fund, established under section 4-52-102;

(5) Outline strategies to:

(A) Promote health systems change;

(B) Address the factors influencing health care cost increases; and

(C) Address the major threats to public health and safety in the state, including, but not limited to, lung disease, diabetes, cancer and heart disease; and

(6) Provide recommendations to help purchasers and providers make decisions that improve public health and build an affordable, high-quality health care system.

(d) The plan must be used in determining the capital investment fund amount pursuant to section 4-52-102 and must guide the issuance of certificates of need by the health services development agency. A certificate of need under title 68, chapter 11, part 16, or public financing that affects health care costs may not be provided unless it meets goals and budgets explicitly outlined in the plan.

4-52-104.

(a) The advisory council on health systems development, is established and is referred to in this section as "the council." The council consists of the following eleven

(11) members appointed by the governor with approval by joint resolution of the general assembly:

(1) Two (2) individuals with expertise in health care delivery;

(2) One (1) individual with expertise in long-term care;

(3) One (1) individual with expertise in mental health;

(4) One (1) individual with expertise in public health care financing;

(5) One (1) individual with expertise in private health care financing;

(6) One (1) individual with expertise in health care quality;

(7) One (1) individual with expertise in public health;

(8) Two (2) representatives of consumers; and

(9) One (1) representative of the department of human services.

Prior to making appointments to the council, the governor shall seek nominations from the public, from statewide associations representing hospitals, physicians and consumers and from individuals and organizations with expertise in health care delivery systems, health care financing, health care quality and public health.

(b) Members of the council serve five-year terms except for initial appointees. Initial appointees must include three (3) members appointed to three-year terms, four (4) members appointed to four-year terms and four (4) members appointed to five-year terms. A member may not serve more than two (2) consecutive terms.

(c) Members of the council are entitled to reimbursement for expenses according to the provisions of the comprehensive travel regulations promulgated by the commissioner of finance and administration.

(d) A quorum is a majority of the members of the council.

(e) The council shall annually choose one (1) of its members to serve as chair for a one-year term.

(f) The council shall meet at least four (4) times a year at regular intervals and may meet at other times at the call of the chair or the governor. Meetings of the council are public proceedings as provided by Title 8, Chapter 44.

(g) The council shall advise the governor in developing the plan by:

(1) Collecting and coordinating data on health systems development in this state;

(2) Synthesizing relevant research; and

(3) Conducting at least two (2) public hearings on the plan and the capital investment fund each biennium.

(h) The governor's office shall provide staff support to the council. The department of human services, department of health, the Tennessee health data organization and other agencies of state government as necessary and appropriate shall provide additional staff support or assistance to the council.

(i) The council shall solicit data and information from both the public and private sectors to help inform the council's work.

(1) The following organizations shall forward data that documents key public health needs, organized by region of the state, to the council annually:

(A) The department of health; and

(B) A statewide public health association.

(2) Public purchasers using state or municipal funds to purchase health care services or health insurance shall, beginning January 1, 2005, submit to the council a consolidated public purchasers expenditure report outlining all funds expended in the most recently completed state fiscal year for hospital inpatient and outpatient care, physician services, prescription drugs, long-term care, mental health and other services and administration, organized by agency.

(3) The council shall encourage private purchasers to develop and submit to the council a health expenditure report similar to that described in subdivision (2).

4-52-105.

The governor shall adopt rules for the implementation of this chapter in accordance with the provisions of Title 4, Chapter 5.

SECTION 7. Tennessee Code Annotated, Section 68-11-1609, is amended by adding the following as a new subsection:

(h) The agency may only approve an application for a health care facility that has been reviewed and approved to the extent required by the agency pursuant to this part that is consistent with the cost containment provisions for health care and health coverage of the State Health Plan adopted pursuant to Title 4, Chapter 52, including, but not limited to, the capital investment fund.

SECTION 8. Tennessee Code Annotated, Title 68, Chapter 1, is amended by adding the following as a new part 22:

68-1-2201.

(a) There is established Tennessee health data organization.

(b) The purposes of the organization are to create and maintain a useful, objective, reliable and comprehensive health information database that is used to improve the health of Tennessee citizens and to issue reports. This database must be publicly accessible while protecting patient confidentiality and respecting providers of care. The organization shall collect, process, analyze and report clinical, financial, quality and restructuring data as defined in this chapter.

(c) The board of the organization shall consist of five (5) members selected by the commissioner of health for four-year terms as follows: two (2) health policy researchers from higher education, one (1) representative of the bureau of TennCare, one (1) representative of the bureau of health services, and one (1) representative of the division of insurance from the department of commerce and insurance. The commissioner of health shall designate one (1) member to serve as chair of the board for each year.

(d) The board shall develop and implement policies and procedures for the collection, processing, storage and analysis of clinical, financial, quality and restructuring data in accordance with this subsection for the following purposes:

(1) To use, build and improve upon and coordinate existing data sources and measurement efforts through the integration of data systems and standardization of concepts;

(2) To coordinate the development of a linked public and private sector information system;

(3) To emphasize data that is useful, relevant and is not duplicative of existing data;

(4) To minimize the burden on those providing data; and

(5) To preserve the reliability, accuracy and integrity of collected data while ensuring that the data is available in the public domain.

(e) The organization may modify the uniform reporting systems for clinical, financial, quality and restructuring data to allow for differences in the scope or type of services and in financial structure among health care facilities, providers or payors subject to this chapter.

(f) The board shall prepare and submit an annual report on the operation of the organization, including any activity contracted for by the organization, and on health care trends to the governor and the standing committees of the general assembly having jurisdiction over health and human services matters no later than February 1st of each year. The report must include an annual accounting of all revenue received and expenditures incurred in the previous year and all revenue and expenditures planned for the next year. The report must include a list of persons or entities that requested data from the organization in the preceding year with a brief summary of the stated purpose of the request.

(g) The rules must establish criteria for determining whether information is confidential clinical data, confidential financial data or privileged medical information and adopt procedures to give affected health care providers, and payors notice and opportunity to comment in response to requests for information that may be considered confidential or privileged.

68-1-2202.

The board shall adopt rules regarding the collection of quality data. The board shall work with the Tennessee quality forum and the Tennessee quality forum advisory council to develop the rules. The rules must be based on the quality measures adopted by the Tennessee quality forum pursuant to section 56-54-201. The rules must specify the content, form, medium and frequency of quality data to be submitted to the organization. In the collection of quality data, the organization must minimize duplication of effort, minimize the burden on those required to provide data and focus on data that may be retrieved in electronic format from within a health care practitioner's office or health care facility. As specified by the rules, health care practitioners and health care facilities shall submit quality data to the organization.

68-1-2203.

(a) The organization shall produce clearly labeled and easy-to-understand reports as follows. Unless otherwise specified, the organization shall distribute the reports on a publicly accessible site on the Internet or via mail or e-mail, through the creation of a list of interested parties. The organization shall publish a notice of the availability of these reports at least once per year in the four (4) daily newspapers of the greatest general circulation published in the state. The organization shall make reports available to members of the public upon request.

(b) At a minimum, the organization, in conjunction with the Tennessee quality forum, established in section 56-54-201, shall develop and produce annual quality reports.

(c) At a minimum, the organization shall develop and produce annual reports on prices charged for the fifteen (15) most common services provided by health care facilities and health care practitioners, excluding emergency services. For health care facilities, the reports must include, but are not limited to, the average price charged per service per facility and total number of services per facility.

(d) At a minimum, the organization shall develop and produce an annual report that compares the fifteen (15) most common diagnosis-related groups and the fifteen (15) most common outpatient procedures for all hospitals in the state and the fifteen (15) most common procedures for nonhospital health care facilities in the state to similar data for medical care rendered in other states, when such data are available.

(e) The organization shall provide an annual report of the ten (10) services and procedures most often provided by physicians in the private office setting in this state. The organization shall distribute this report to all physician practices in the state. The first report must be produced by July 1, 2005.

SECTION 9 Tennessee Code Annotated, Title 63, Chapter 1, Part 1, is amended by adding the following as a new section:

63-1-145.

A health care practitioner regulated under this title shall notify patients in writing of the health care practitioner's charges for health care services commonly offered by the practitioner. Upon request of a patient, a health care practitioner shall assist the patient in determining the actual payment from a 3rd-party payor for a health care service commonly offered by the practitioner. A patient may file a complaint with the appropriate licensing board regarding a health care practitioner who fails to provide the consumer information required by this section.

SECTION 10 Tennessee Code Annotated, Title 56, Chapter 29, is amended by adding the following as a new section:

56-29-121.

All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician or chiropractor health care practitioner must accept the current standardized claim form for professional services approved by the federal government and submitted electronically. All nonprofit hospital or medical service organizations and nonprofit health care plans providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the federal government and submitted electronically. A nonprofit hospital or medical service organization or nonprofit health care plan may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to law.

SECTION 11. Tennessee Code Annotated, Title 63, Chapter 1, Part 1, is amended by adding the following as a new section:

63-1-146.

A health care practitioner, who directly bills for health care services must use the current standardized claim form for professional services approved by the federal government and, after October 16, 2004, must submit claims in electronic data format to a carrier, that accepts claims in an electronic format. A health care practitioner or group of health care practitioners with fewer than ten (10) full-time-equivalent health care practitioners and other employees is exempt from the requirement to submit claims in electronic data format until October 16, 2006. Beginning October 16, 2006, a health care practitioner or group of health care practitioners with fewer than ten (10) full-time-equivalent health care practitioners and other employees may apply to the commissioner of commerce and insurance for a continued exemption from the requirement to submit claims in electronic data format based upon hardship. The commissioner of commerce and insurance shall adopt rules relating to the process for a hardship exemption and the standard for determining whether a practitioner has demonstrated hardship.

SECTION 12. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section.

56-7-1014.

All administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the federal government and submitted electronically. All administrators who administer claims and who provide payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the federal government and submitted electronically. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to law.

SECTION 13. Tennessee Code Annotated, Title 56, Chapter 7, Part 10, is amended by adding the following as a new section:

56-7-1015.

Administrators providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed physician, chiropractor health care practitioner or licensed hospital shall accept the current standardized claim form for professional or facility services, as applicable, approved by the federal government and submitted electronically. An administrator may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to law.

SECTION 14. Tennessee Code Annotated, Section 56-7-1008, is amended by adding the following as new subsections (d) and (e):

(d) All insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a health care practitioner must accept the current standardized claim form for professional services approved by the federal government and submitted electronically. All insurers providing individual medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the federal government and submitted electronically. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to law.

(e) All insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the federal government and submitted electronically. All insurers providing group medical expense insurance on an expense-incurred basis providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the federal government and submitted electronically. An insurer may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to law.

SECTION 15. Tennessee Code Annotated, Title 56, Chapter 32, Part 2, is amended by adding the following as a new section:

56-32-239.

All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed health care practitioner must accept the current standardized claim form for professional services approved by the federal government and submitted electronically. All health maintenance organizations providing payment or reimbursement for diagnosis or treatment of a condition or a complaint by a licensed hospital must accept the current standardized claim form for professional or facility services, as applicable, approved by the federal government and submitted electronically. A health maintenance organization may not be required to accept a claim submitted on a form other than the applicable form specified in this section and may not be required to accept a claim that is not submitted electronically, except from a health care practitioner who is exempt pursuant to law.

SECTION 16. Tennessee Code Annotated, Title 56, Chapter 29, Part 1, is amended by adding the following as a new section:

56-29-122.

A group health care contract may not be issued by a nonprofit hospital or medical service organization in this state until a copy of the group rates to be used in calculating the premium for these contracts has been filed for informational purposes with the commissioner of commerce and insurance. The filing must include the base rates and a description of any procedures to be used to adjust the base rates to reflect factors including but not limited to age, gender, health status, claims experience, group size and coverage of dependents. Notwithstanding this section, rates for group Medicare supplement, nursing home care or long-term care contracts and for certain group contracts included within the definition of "individual health plan" shall be filed in accordance with the provisions of Title 56, Chapter 5, and rates for small group health plans under section 56-5-325(d), (e) and (f) shall be filed in accordance with that section.

SECTION 17. Tennessee Code Annotated, Title 56, Chapter 5, Part 3, is amended by adding the following as a new section:

56-5-324.

(a) The provisions of sections 56-5-324, 56-5-325, and 56-5-326, inclusive, shall apply only to the filing of health plans or health insurance policies and related reports.

(b) Each health insurer and health maintenance organization shall file an annual report supplement on or before March 1st of each year, or within any reasonable extension of time that the commissioner of commerce and insurance for good cause may have granted on or before March 1st. The commissioner shall adopt rules regarding specifications for the annual report supplement. The annual report supplements must provide the public with general, understandable and comparable financial information relative to the in-state operations and results of authorized insurers and health maintenance organizations. Such information must include, but is not limited to, medical claims expense, administrative expense and underwriting gain for each line segment of the market in this state in which the insurer participates. The annual report supplements must contain sufficient detail for the public to understand the components of cost incurred by authorized health insurers and health maintenance organizations as well as the annual cost trends of these carriers. The commissioner shall develop standardized definitions of each reported measure.

SECTION 18. Tennessee Code Annotated, Title 56, Chapter 5, Part 3, is amended by adding the following as a new section:

56-5-325.

(a) If at any time the commissioner has reason to believe that a filing for a health plan or health insurance policy does not meet the requirements that rates shall not be excessive, inadequate, or unfairly discriminatory or not in compliance with section 56-54-113 or that the filing violates any of the provisions of this chapter, the commissioner shall cause a hearing to be held. The burden of proving that rates are adequate, not unfairly discriminatory and in compliance with section 56-54-113 is with the insurer.

(b) A health insurance carrier that adjusts its rate shall account for the savings offset payment or any recovery in that offset payment in its experience consistent with this section and section 56-54-113.

(c) For all policies and certificates issued on or after the effective date of this section, the commissioner shall disapprove any premium rates filed by any carrier, whether initial or revised, for an individual health policy unless it is anticipated that the aggregate benefits estimated to be paid under all the individual health policies maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least sixty-five percent (65%) of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any savings offset payments paid pursuant to section 56-54-113 must be treated as incurred claims.

(d) A carrier offering small group health plans shall file with the commissioner the rates for each plan and every rate, rating formula and classification of risks and every modification of any formula or classification that it proposes to use.

(1) Every filing must state the effective date of the filing. Every filing must be made not less than sixty (60) days in advance of the stated effective date, unless the sixty day requirement is waived by the commissioner. The effective date may be suspended by the commissioner for a period of time not to exceed

thirty (30) days. In the case of a filing that meets the criteria in subdivision (e), the commissioner may suspend the effective date for a longer period not to exceed thirty (30) days from the date the carrier satisfactorily responds to any reasonable discovery requests.

(2) A filing and supporting information are public records except as provided by Title 10, Chapter 7, Part 5, and become part of the official record of any hearing held pursuant to subdivision (e)(2) or (6).

(3) Rates for small group health plans must be filed in accordance with this section and subsections (e) and (f) for premium rates effective on or after July 1, 2005, except that the filing of rates for small group health plans are not required to account for any savings offset payment or any recovery of that offset payment pursuant to subdivision (e)(4) of this section and section 56-54-113 for rates effective before July 1, 2006.

(e) Except as provided in subsection (f), rate filings are subject to this subsection.

(1) The commissioner shall disapprove any premium rates filed by any carrier, whether initial or revised, for a small group health plan unless it is anticipated that the aggregate benefits estimated to be paid under all the small group health plans maintained in force by the carrier for the period for which coverage is to be provided will return to policyholders at least seventy-five percent (75%) of the aggregate premiums collected for those policies, as determined in accordance with accepted actuarial principles and practices and on the basis of incurred claims experience and earned premiums. For the purposes of this calculation, any savings offset payments paid pursuant to section 56-54-113 must be treated as incurred claims.

(2) If at any time the commissioner has reason to believe that a filing does not meet the requirements that rates not be excessive, inadequate or unfairly discriminatory or that the filing violates any of the provisions of this chapter, the commissioner shall cause a hearing to be held. The commissioner shall issue an order or decision within thirty (30) days after the close of the hearing or of any

rehearing or reargument or within such other period as the commissioner for good cause may require, but not to exceed an additional thirty (30) days. In the order or decision, the commissioner shall either approve or disapprove the rate filing. If the commissioner disapproves the rate filing, the commissioner shall establish the date on which the filing is no longer effective, specify the filing the commissioner would approve and authorize the insurer to submit a new filing in accordance with the terms of the order or decision.

(3) When a filing is not accompanied by the information upon which the carrier supports the filing or the commissioner does not have sufficient information to determine whether the filing meets the requirements that rates not be excessive, inadequate, unfairly discriminatory or not in compliance with section 56-54-113, the commissioner shall require the carrier to furnish the information upon which it supports the filing.

(4) A carrier that adjusts its rate shall account for the savings offset payment or any recovery of that savings offset payment in its experience consistent with this section and section 56-54-113.

(5) Any filing of rates, rating formulas and modifications that satisfies the criteria set forth in this subsection is subject to the provisions of subdivision (6):

(A) The proposed rate for any group or subgroup does not include a unit cost change that exceeds the index of inflation multiplied by 1.5, excluding any approved rate differential based on age. For the purposes of this item, "index of inflation" means the rate of increase in medical costs for a section of the United States selected by the commissioner that includes this state for the most recent twelve-month period immediately preceding the date of the filing for which data are available; and

(B) The carrier demonstrates in accordance with generally accepted actuarial principles and practices consistently applied that, as of a date no more than two hundred ten (210) days prior to the filing, the ratio of benefits incurred to premiums earned averages no less than seventy-eight percent (78%) for the previous thirty-six-month period.

(6) Any rate hearing conducted with respect to filings that meet the criteria in subdivision (5) is subject to this subdivision.

(A) A person requesting a hearing shall provide the commissioner with a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in subdivision (5).

(B) If the commissioner decides to hold a hearing, the commissioner shall issue a written statement detailing the circumstances that justify a hearing, notwithstanding the satisfaction of the criteria in subdivision (5).

(C) In any hearing conducted under this subdivision, the bureau and any party asserting that the rates are excessive have the burden of establishing that the rates are excessive. The burden of proving that rates are adequate, not unfairly discriminatory and in compliance with the requirements of section 56-54-113 remains with the carrier.

(f) Notwithstanding subsection (e), at the carrier's option, rate filings for a credible block of small group health plans may be filed in accordance with this subsection instead of subsection (e). Rates filed in accordance with this subsection are filed for informational purposes.

(1) A block of small group health plans is considered credible if the anticipated number of member months for which the rates will be in effect is at least one thousand (1,000) or if it meets credibility standards adopted by the commissioner by rule. The rate filing must state the anticipated number of member months for which the rates will be in effect and the basis for the estimate. If the commissioner determines that the number of member months is likely to be less than one thousand (1,000) and the block does not satisfy any alternative credibility standards adopted by rule, the filing is subject to subsection (e).

(2) On an annual schedule as determined by the commissioner, the carrier shall file a report with the commissioner showing aggregate earned premiums and incurred claims for the period the rates were in effect. Incurred claims must include claims paid to a date six (6) months after the end of the annual reporting period determined by the commissioner and an estimate of unpaid claims. The report must state how the unpaid claims estimate was determined.

(3) If incurred claims were less than seventy-eight percent (78%) of aggregate earned premiums over a continuous thirty-six-month period, the carrier shall refund a percentage of the premium to the current in-force policyholder. For the purposes of calculating this loss-ratio percentage, any savings offset payments paid pursuant to section 56-54-113 must be treated as incurred claims. The excess premium is the amount of premium above that amount necessary to achieve a seventy-eight percent (78%) loss ratio for all of the carrier's small group policies during the same thirty-six-month period. The refund must be distributed to policyholders in an amount reasonably calculated to correspond to the aggregate experience of all policyholders holding policies having similar benefits. The total of all refunds must equal the excess premiums.

(A) For determination of loss-ratio percentages in 2006, actual aggregate incurred claims expenses include expenses incurred in 2006 and projected expenses for 2007 and 2008. For determination of loss-ratio percentages in 2007, actual incurred claims expenses include expenses in 2006 and 2007 and projected expenses for 2008.

(B) The commissioner may waive the requirement for refunds during the first three (3) years after the effective date of this subsection.

(4) The commissioner may require further support for the unpaid claims estimate and may require refunds to be recalculated if the estimate is found to be unreasonably large.

(5) The commissioner may adopt rules setting forth appropriate methodologies regarding reports, refunds and credibility standards pursuant to this subsection.

SECTION 19. Tennessee Code Annotated, Title 56, Chapter 5, Part 3, is amended by adding the following as a new section:

56-5-326.

(a) This section applies to group health insurance offered in the large group market, except insurance covering only accidental injury, specified disease, hospital indemnity, dental, vision, disability income, long-term care, Medicare supplement or other limited benefit health insurance.

(b) Every carrier offering group health insurance specified in subsection (a) shall annually file with the commissioner of commerce and insurance on or before April 30th a certification signed by a member in good standing of the American Academy of Actuaries or a successor organization that the carrier's rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board. The filing must also certify that the carrier has included in its experience any savings offset payments or recovery of those savings offset payments consistent with section 56-54-113. The filing also must state the number of policyholders, certificate holders and dependents, as of the close of the preceding calendar year, enrolled in large group health insurance plans offered by the carrier. A filing and supporting information are public records except as provided by Title 10, Chapter 7, Part 5.

(c) Every carrier shall maintain at its principal place of business a complete and detailed description of its rating practices, including information and documentation that demonstrates that its rating methods and practices are in accordance with generally accepted actuarial principles and with the applicable actuarial standards of practice as promulgated by an actuarial standards board.

SECTION 20. Tennessee Code Annotated, Title 56, Chapter 32, Part 2, is amended by adding the following as a new section:

56-32-239.

A schedule or an amendment to a schedule of charge for enrollee health coverage for health care services may not be used by any health maintenance organization unless it complies with the provisions of Title 56, Chapter 5, Part 3.

SECTION 21. Tennessee Code Annotated, Title 56, Chapter 32, Part 2, is amended by adding the following as a new section:

56-32-240.

(a) Except as provided in subsection (b), a managed health insurance issuer, as defined in section 56-32-228, offering a managed care plan shall provide to its members reasonable access to health care services in accordance with standards developed by rule by the commissioner. These standards must consider the geographical and transportational problems in rural areas. All such managed care plans covering residents of this state must provide reasonable access to providers consistent with the access-to-services requirements of any applicable bureau rule.

(b) Upon approval of the commissioner, a carrier may offer a health plan that includes financial provisions designed to encourage members to use designated providers in a network if:

(1) The entire network meets overall access standards established by rule;

(2) The health plan is consistent with product design guidelines established by rule;

(3) The health plan does not include financial provisions designed to encourage members to use designated providers of primary, preventive, maternity, obstetrical, ancillary or emergency care services, as defined by rule;

(4) The financial provisions may apply to all of the enrollees covered under the carrier's health plan;

(5) The carrier establishes to the satisfaction of the commissioner that the financial provisions permit the provision of better quality services and the quality improvements either significantly outweigh any detrimental impact to covered

persons forced to travel longer distances to access services, or the carrier has taken steps to effectively mitigate any detrimental impact associated with requiring covered persons to travel longer distances to access services. The commissioner of commerce and insurance may consult with other state entities, including the department of human services, department of health and the Tennessee quality forum, to determine whether the carrier has met the requirements of this subdivision. The commissioner shall adopt public necessity rules by January 1, 2005 regarding the criteria used by the commissioner to determine whether the carrier meets the quality requirements of this subdivision and present those rules for legislative review; and

(6) The financial provisions may not permit travel at a distance that exceeds the standards established by rule for mileage and travel time by one hundred percent (100%).

(c) This section takes effect January 1, 2005 and is repealed July 1, 2008.

SECTION 22.

(a) In order to control the rate of growth of costs of health care and health coverage, the general assembly asks the cooperation of health care practitioners, hospitals and health insurance carriers.

(1) Each health care practitioner, regulated under Tennessee Code Annotated, Title 63, is asked to limit the growth of net revenue of the practitioner's practice to three percent (3%) for the practitioner's fiscal year beginning July 1, 2004 and ending June 30, 2005.

(2) Each hospital licensed under Title 68, Chapter 11, is asked to voluntarily restrain cost increases, measured as expenses per case mix adjusted discharge, to no more than three and one-half percent (3.5%) for the hospital fiscal year beginning July 1, 2004 and ending June 30, 2005. Each hospital is asked to voluntarily hold hospital consolidated operating margins to no more than three percent (3%) for the hospital's fiscal year beginning July 1, 2004 and ending June 30, 2005.

(3) Each health insurance carrier licensed in this state is asked to voluntarily limit the pricing of products it sells in this state to the level that supports no more than three percent (3%) underwriting gain less federal taxes for the carrier's fiscal year beginning July 1, 2004 and ending June 30, 2005.

(b) By January 1, 2005, the Tennessee hospital association and the governor's office shall agree on a timetable, format and methodology for the hospital association to report on hospital charges, cost efficiency and consolidated operating margins. In accordance with the agreement, the Tennessee Hospital Association shall report to the governor and the joint standing committee having jurisdiction over health and human services matters.

SECTION 23. The department of finance and administration shall conduct a comprehensive review of reimbursement rates in the TennCare program and shall report the results of that review to the standing committees of the general assembly having jurisdiction over health and human services matters by January 15, 2006. The review must provide opportunity for input from health care consumers, providers, practitioners and insurance carriers and must include consideration of the costs of providing health care in different settings, reflecting the recovery offset in bad debt and charity care, and a review of rates paid in other states and by insurance carriers and the Medicare program. The review must also identify options and costs for increasing rates and must propose strategies for achieving stated priorities. The joint standing committee having jurisdiction over health and human services matters may report out legislation on TennCare provider rates.

SECTION 24. The commissioner of finance and administration is directed to obtain any necessary waivers, waiver modifications or other approvals necessary from the federal department of health and human services in order to implement the VolunteerCare program in association with the TennCare program or its successor programs. If the necessary approvals cannot be obtained, then Section 1 of this act shall not take effect and the remaining provisions of this act shall take effect only to the extent the commissioner determines that such provisions may be implemented without the necessary approvals from the federal government.

SECTION 25. Tennessee Code Annotated, Section 4-29-227(a), is amended by adding the following as new items:

( ) Board of directors of VolunteerCare Health, created by § 56-54-101;

( ) Tennessee quality form advisory council, created by § 56-54-202;

( ) Advisory council on health systems development, created by § 4-52-104;

( ) Tennessee health data organization, created by § 68-1-2201.

SECTION 26. The commissioner of finance and administration is authorized to promulgate rules and regulations to effectuate the purposes of this act. All such rules and regulations shall be promulgated in accordance with the provisions of Tennessee Code Annotated, Title 4, Chapter 5.

SECTION 27. The provisions of this act shall not be construed to be an appropriation of funds and no funds shall be obligated or expended pursuant to this act unless such funds are specifically appropriated by the general appropriations act.

SECTION 28. If any provision of this act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to that end the provisions of this act are declared to be severable.

SECTION 29. This act shall take effect July 1, 2004, the public welfare requiring it